BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: CARRIE SUE ARMSTRONG 1001 Oleander Avenue # 13 Bakersfield, CA 93304 Registered Nurse License No. 630182 Respondent	Case No. 2007-259

DEFAULT DECISION AND ORDER

The attached Default Decision and Order is hereby adopted by the Board of Registered Nursing, Department of Consumer Affairs, as its Decision in the above entitled matter.

This Decision shall become effective on **November 4, 2007**.

IT IS SO ORDERED **October 4, 2007**

La Francine W Tate

President
Board of Registered Nursing
Department of Consumer Affairs
State of California

EDMUND G. BROWN JR., Attorney General
of the State of California
GLORIA A. BARRIOS
Supervising Deputy Attorney General
GREGORY J. SALUTE, State Bar No. 164015
Deputy Attorney General
California Department of Justice
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 897-2520
Facsimile: (213) 897-2804

Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: CARRIE SUE ARMSTRONG 1001 Oleander Avenue #13 Bakersfield, Ca. 93304 Registered Nurse License No. 630182 Respondent.	Case No. 2007-259 OAH No. Unassigned **DEFAULT DECISION AND ORDER** [Gov. Code, §11520]

FINDINGS OF FACT

1. On or about April 25, 2007, Complainant Ruth Ann Terry, M.P.H, R.N, in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs, filed Accusation No.2007-259 against Carrie S. Armstrong (Respondent) before the Board of Registered Nursing.

2. On or about December 15, 2003, the Board of Registered Nursing (Board) issued Registered Nurse License No. 630182 to Respondent. The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2007, unless renewed.

3. On or about July 3, 2007, Teresa Sutton, an employee of the Department of Justice, served by Certified and First Class Mail a copy of the Accusation No. 2007-259,

Statement to Respondent, Notice of Defense, Request for Discovery, and Government Code sections 11507.5, 11507.6, and 11507.7 to Respondent's address of record with the Board, which was and is 1001 Oleander Avenue #13, Bakersfield, Ca. 93304. A copy of the Accusation, the related documents, and Declaration of Service are attached as exhibit A, and are incorporated herein by reference.

4. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c).

5. On or about July 11, 2007, the aforementioned documents were returned by the U.S. Postal Service marked "Forwarding Address Expired." A copy of the envelope returned by the post office is attached as exhibit B, and is incorporated herein by reference.

6. Government Code section 11506 states, in pertinent part:

"(c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing."

7. Respondent failed to file a Notice of Defense within 15 days after service upon her of the Accusation, and therefore waived her right to a hearing on the merits of Accusation No.2007-259.

8. California Government Code section 11520 states, in pertinent part:

"(a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent."

9. Pursuant to its authority under Government Code section 11520, the Board finds Respondent is in default. The Board will take action without further hearing and, based on Respondent's express admissions by way of default and the evidence before it, contained in exhibits A, B and C, finds that the allegations in Accusation No. 2007-259 are true.

10. The total costs for investigation and enforcement are $31,720.50 as of July

31, 2007.

DETERMINATION OF ISSUES

1. Based on the foregoing findings of fact, Respondent Carrie S. Armstrong has subjected her Registered Nurse License No. 630182 to discipline.

2. A copy of the Accusation and the related documents and Declaration of Service are attached.

3. The agency has jurisdiction to adjudicate this case by default.

4. The Board of Registered Nursing is authorized to revoke Respondent's Registered Nurse License based upon the following violations alleged in the Accusation:

a. Respondent is subject to disciplinary action under section 2761, subdivision (a) and (d), defined by section 2762, subdivision (e), and California Code of Regulations, title 16, section 1444, in that Respondent falsified, made grossly incorrect, grossly inconsistent, and/or unintelligible entries in hospital and patient records pertaining to controlled substances.

b. Respondent is subject to disciplinary action under section 2761, subdivision (a), as defined in section 2762, subdivision (a), and 4060, on the grounds of unprofessional conduct, in that from on or about December 6, 2003, to on or about January 9, 2004, Respondent obtained and possessed the controlled substances and dangerous drugs, Ativan, Morphine, Demerol and Dilaudid, at will, without physicians' orders when she did not administer or waste the possessed medications as required by hospital procedures.

c. Respondent is subject to disciplinary action under section 2761, subdivision (a), on the grounds of unprofessional conduct, in that while employed as a registered nurse, Respondent committed unprofessional acts which directly relate to the qualifications, functions, and duties of a registered nurse.

d. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1), on the grounds of gross negligence and/or incompetence in carrying out the usual certified or licensed nursing functions in that Respondent obtained and

administered controlled substances without a doctor's order or prescription, and made multiple errors and/or falsifications in multiple patient medical records.

e. Respondent is subject to disciplinary action under Sections 2750 and 2762, subdivision (b), on the grounds of unprofessional conduct, in that Respondent administered to herself a controlled substance without a prescription to an extent or in a manner dangerous or injurious to herself, any other person, or the public or to the extent that such use impairs her ability to conduct with safety to the public the practice authorized by his or her license.

ORDER

IT IS SO ORDERED that Registered Nurse License No. 630182, heretofore issued to Respondent Carrie S. Armstrong, is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on November 4, 2007.

It is so ORDERED October 4, 2007

La Francine W Tate

FOR THE BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS

60234407.wpd
DOJ docket number:LA2006600951

Attachments:

Exhibit A: Accusation No. , Related Documents, and Declaration of Service
Exhibit B: Copy of Envelope Returned by Post Office

Exhibit A

Accusation No. 2007-259,
Related Documents and Declaration of Service

EDMUND G. BROWN JR., Attorney General
of the State of California
GLORIA BARRIOS
Supervising Deputy Attorney General
GREGORY J. SALUTE, State Bar No. 164015
Deputy Attorney General
California Department of Justice
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 897-2520
Facsimile: (213) 897-2804

Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: CARRIE SUE ARMSTRONG 1001 Oleander Avenue #13 Bakersfield, Ca. 93304 Registered Nurse License No. 630182 Respondent.	Case No. 2007-259 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs (Board).

2. On or about December 15, 2003, the Board issued Registered Nurse License No. 630182 to Carrie Sue Armstrong (Respondent). The Registered Nurse License will expire on October 31, 2007, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and

Professions Code unless otherwise indicated.

4. Section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

6. Section 2761 states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

Section 2761 states, in pertinent part:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

. . . .

"(d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter [the Nursing Practice Act] or regulations adopted pursuant to it. . . ."

7. Section 2762 states, in pertinent part:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is

unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

. . . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

8. Section 4060 states, in pertinent part:

"No person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, or veterinarian, or furnished pursuant to a drug order issued by a certified nurse-midwife pursuant to Section 2746.51, a nurse practitioner pursuant to Section 2836.1, or a physician assistant pursuant to Section 3502.1."

9. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

10. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

11. California Code of Regulations, title 16, section 1444, states:

"A[n] . . . act shall be considered to be substantially related to the qualifications, functions or duties of a registered nurse if to a substantial degree it evidences the present or potential unfitness of a registered nurse to practice in a manner consistent with the public health, safety, or welfare. Such . . . acts shall include but not be limited to the following:

. . . .

"(c) Theft, dishonesty, fraud, or deceit. . . ."

12. Health and Safety Code section 11377(a) provides that it is illegal to possess a controlled substance without a valid prescription.

13. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DEFINITIONS

14. **Ativan**, a brand of lorazepam, a benzodiazepine derivative, is a Schedule IV controlled substance as designated by Health and Safety Code section 11057(d)(11).

15. **Demerol**, a brand of meperidine hydrochloride, a derivative of pethidine, is a Schedule II controlled substance as designated by Health and Safety Code section 11055(c)(16) and is categorized as a dangerous

drug pursuant to section 4211 of the Code.

16. **Dilaudid**, Opium derivative, is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(k) and is categorized as a dangerous drug pursuant to section 4022 of the Code.

17. **Morphine/Morphine Sulfate**, is a Schedule II controlled substance pursuant to Health and Safety Code Section 11055(b)(1)(M) and a dangerous drug pursuant to Business and Professions Code section 4022.

18. **Pyxis Medication Station:** The Pyxis Medication Station is a computerized medication dispensing station that allows users to obtain medications using a user name and personal identification number (PIN). The user enters the patients name and medication prescribed. The Pyxis station records the date and time the medication was removed for use.

19. **Omnicell Medication Station:** The Omnicell Medication Station is a computerized medication dispensing station that allows users to obtain medications using a user name and personal identification number (PIN). The user enters the patients name and medication prescribed. The Omnicell Station records the date and time the medication was removed for use.

FIRST CAUSE FOR DISCIPLINE

(Falsified/Unintelligible Hospital Records)

20. Respondent is subject to disciplinary action under section 2761, subdivision (a) and (d), defined by section 2762, subdivision (e), and California Code of Regulations, title 16, section 1444, in that Respondent falsified, made grossly incorrect, grossly inconsistent, and/or unintelligible entries in hospital and patient records pertaining to controlled substances in the following respects:

MERCY HOSPITAL-BAKERSFIELD

21. From on or about December 6, 2003 to on or about

January 9, 2004, while employed as a registered nurse at Mercy Hospital in Bakersfield, California, Respondent committed unprofessional conduct and acts of dishonesty in falsifying medical records, as follows:

Patient #J11979754

a. Physician's orders for this patient on December 6, 2003 at 1840 hours called for Morphine 2 mg every four hours as needed for pain. The Pyxis medication station records revealed that Respondent removed Morphine 2 mg. on December 8, 2003 at 1946 hours and again at 2217 hours. The Medication Administration Record (MAR) documents that Respondent administered Morphine 2 mg to this patient at 1900 hours and again at 2230 hours. Respondent documented in the December 8, 2003 medical records for this patient that she administered Morphine to this patient 46 minutes before she withdrew the medication from the Pyxis machine.

The Pyxis medication records also reveal that on December 9, 2003, at 0113 hours, Respondent withdrew Morphine 4 mg. The MAR documents that Respondent administered Morphine 2 mg. to the above patient at 0130 hours. The medical records completed by Respondent for December 9, 2003 fail to document a waste or otherwise account for 2 mg. of Morphine.

The physicians' orders for this patient on December 6, 2003 at 1840 hours also called for Ativan .5mg -1 mg every four hours as needed for pain. The Pyxis medication records reveal that on December 8, 2003, at 2028 hours, Respondent withdrew Ativan 2 mg. Injection with no waste noted. The MAR for December 8, 2003 at 2030 hours does not reveal a dose given to this patient. The medical records completed by Respondent for December 8, 2003 fail to document a waste or otherwise account for 2 mg. of Ativan.

The Pyxis medication records for December 9, 2003 reveal that

Respondent removed Ativan 2 mg. Injection with no waste noted at 0024 hours and at 0402 hours. The MAR reveals that Respondent administered Ativan 1 mg. at 0030 hours and again at 0410 hours with no dose noted.

The medical records completed by Respondent for December 9, 2003 fail to document a waste or otherwise account for 4 mg. (Inj.) of Ativan.

Patient #J11985314

b. The physician's order for this patient on December 8, 2003 at 1840 hours were Morphine, 1 mg. every four hours as needed for pain. The Pyxis medication station records reveal that on December 9, 2003, at 0115 hours, Respondent withdrew Morphine 4 mg. (Inj.). The MAR reveals that on December 9, 2003, Respondent administered Morphine 1 mg. to this patient at 0130 hours. The medical records completed by Respondent for December 9, 2003 fail to document a waste or otherwise account for 3 mg. (Inj.) of Morphine. The Pyxis medication records also reveal that on December 9, 2003 at 0344 hours, Respondent withdrew Demerol 50 mg. (Inj.) despite no physician's order for this medication. No administration of this drug is charted by Respondent. Respondent documented that she wasted this drug at 0535 hours. The physician's order for this patient on December 23, 2003 at 1430 hours indicate that this patient was to receive Dilaudid 0.5 mg IV every 3 hours for severe pain as needed. The Pyxis medication station records reveal that Respondent withdrew Dilaudid 2 mg. (Inj.) on December 24, 2003 at 2005 hours, December 24, 2003 at 2216 hours, December 25, 2003 at 0247 hours, December 25, 2003 at 0515 hours, December 28, 2003 at 2057 hours, December 28, 2003 at 2250 hours, and December 29, 2003 at 0641 hours. The MAR records reveal that Respondent administered Dilaudid 0.5 mg. on December 24, 2003 at 2050 hours, December 24, 2003 at 2300 hours,

December 25, 2003 at 0300 hours, December 25, 2003 at 0530 hours, December 28, 2003 at 2250 hours, and December 29, 2003 at 0750 hours. The medical records completed by Respondent for administration of Dilaudid to this patient fail to document a waste or otherwise account for 11 mg. of Dilaudid.

Patient #J12031837

c. Physician's orders for this patient on December 23, 2003 at 1430 hours called for Dilaudid 0.5 mg. IV every three hours as needed for severe pain. The Pyxis medication station records revealed that Respondent removed Dilaudid 2 mg. Inj. on December 24, 2003 at 2005 hours, Dilaudid 2 mg. Inj. on December 24, 2003 at 2216 hours, Dilaudid 2 mg. Inj. on December 25, 2003 at 0247 hours, Dilaudid 2 mg. Inj. on December 25, 2003 at 0515 hours, Dilaudid 2 mg. Inj. on December 28, 2003 at 2057 hours, Dilaudid 2 mg. Inj. on December 28, 2003 at 2250 hours, and Dilaudid 2 mg. Inj. on December 29, 2003 at 0641 hours. The Medication Administration Record (MAR) documents administration of 0.5 Dilaudid to this patient on December 24, 2003 at 2050 hours, 0.5 Dilaudid to this patient on December 24, 2003 at 2300 hours, 0.5 Dilaudid to this patient on December 25, 2003 at 0300 hours, 0.5 Dilaudid to this patient on December 25, 2003 at 0530 hours, 0.5 Dilaudid to this patient on December 28, 2003 at 2250 hours, and 0.5 Dilaudid to this patient on December 29, 2003 at 0750 hours. The medical records completed by Respondent for administration of Dilaudid to this patient fail to document a waste or otherwise account for 11 mg. of Dilaudid.

Patient #J12024667

d. The Pyxis medication station records reveal that on December 26, 2003 at 2121 hours Respondent withdrew Morphine 10 mg. (Inj.) and at 2345 hours, Respondent withdrew another Morphine 10 mg.

(Inj.) This patient had no physician order for Morphine. Moreover, Respondent was off work on December 26, 2003 and had no reason to be withdrawing Morphine from the Pyxis medication station.

Patient #J12044863

e. Physician's orders for this patient on December 26, 2003 called for Demerol 25 mg. IV every four hours as needed for pain. The Pyxis medication station records revealed that Respondent removed Demorol 25 mg. on December 27, 2003 at 0053 hours and again at 0549 hours. The Medication Administration Record (MAR) fails to document any administration of Demerol to this patient on December 27, 2003. Respondent noted in her nursing notes at 0515 hours that pain medications were given as ordered. However, the medical records completed by Respondent for administration of Demerol to this patient fail to document a waste or otherwise account for 50 mg. of Demerol.

Patient #J12032983

f. The physician's orders for this patient on December 22, 2003 at 1430 hours called for Dilaudid 0.8 mg. IV every 6 hours as needed for pain, and Vicodin, one 5 mg. tablet given orally, every 6 hours as needed for pain. The Pyxis medication station records revealed that Respondent removed Dilaudid 2 mg. at 0114 hours, and 0540 hours and one Vicodin 7.5 mg tablet at 0119 and 0543 hours. The MAR fails to document any administration of Dilaudid to this patient by Respondent. Respondent noted in her nursing notes at hours that pain medications were given as ordered. However, the medical records completed by Respondent for administration of Dilaudid to this patient fail to document a waste or otherwise account for 4 mg. of Dilaudid and 5 mg. Vicodin.

Patient #J12049029

g. Despite no physician order for Demerol, the Pyxis

medication station records document that on December 29, 2003, at 0340 Respondent withdrew Demerol 50 mg and that the Demerol was wasted at 0433 hours. The MAR fails to document any administration of Demerol to this patient by Respondent.

Patient #J12048294

h. The physician's order for December 28, 2003 at 1650 hours indicates that this patient is to receive Dilaudid 2-4 mg IVP every 3 to 4 hours as needed. The Pyxis medication station record documents that on January 2, 2004, at 2229 hours, Respondent withdrew 2 doses of Dilaudid 2 mg. (total 4 mg), on January 3, 2004 at 0008 hours, Respondent withdrew Dilaudid 2 mg, on January 3, 2004 at 0046 hours, Respondent withdrew Dilaudid 2 mg., on January 3, 2004 at 0255 hours, Respondent withdrew 2 doses of Dilaudid 2 mg. (total 4 mg.) and on January 3, 2004 at 0512 hours, Respondent withdrew 2 doses of Dilaudid 2 mg. (total 4 mg.) The MAR record indicates that on January 2, 2004 at 2130 hours, Respondent administered an unknown dose of Dilaudid to the patient, on January 3, 2004, at 0330 hours, Respondent administered Dilaudid 4 mg. to the patient, and on January 3, 2004 at 0630 hours, Respondent administered an unknown dose of Dilaudid to the patient. Respondent obtained the doses of Dilaudid within less than the 3 hour time frame ordered by the physician. Further, the medical records completed by Respondent for administration of Dilaudid to this patient fail to document a waste or otherwise account for 4 mg. of Dilaudid. Respondent's nursing notes indicate that on 2312 hours, pain medications were given per the doctor's order and on 0024 hours that there is no complaints of pain at this time.

Patient #J12065017

i. This patient's physician order for Demerol was discontinued January 7, 2004 at 2030 hours. Respondent documented D/C

in the patient record. On January 8, 2004, at 0049 hours, Respondent's nursing notes indicate that IV medications had changed to as needed medicines per doctor's orders and that the patient was in no apparent distress at the time. The Pyxis medication station records document that on January 7, 2004, at 02235 hours, and January 8, 2004 at 0336 hours, Respondent withdrew Demerol 50 mg. The MAR documents that on January 7, 2004, at 2300 hours, Respondent administered Demerol 50 mg. to this patient. The MAR fails to document any other administration of Demerol to this patient by Respondent. The medical records completed by Respondent for administration of Demerol to this patient fail to document a waste or otherwise account for Demerol 50 mg.

BAKERSFIELD HEART HOSPITAL

22. From on or about November 5, 2004 to on or about November 8, 2004 while employed as a registered nurse at Bakersfield Heart Hospital in Bakersfield, California, Respondent committed unprofessional conduct and acts of dishonesty in that Respondent falsified, made grossly incorrect, grossly inconsistent, and/or unintelligible entries, as follows:

Patient #130618

a. Physician's orders for this patient on November 5, 2004 indicate Morphine 4 mg. at time of sheath removal and on November 5, 2004 for Morphine Sulfate 4 mg IV every 6 hours for severe pain (8-10). The Omnicell medication station record indicates that Respondent withdrew Morphine 4 mg. (Inj.) on November 5, 2004 at 2340 hours, on November 6, 2004, at 2456 hours, on November 6, 2004, at 0349 hours, and on November 6, 2004 at 0532 hours. Respondent documented on the Omnicell medication station record that on November 6, 2004 at 0154 hours she wasted 3 mg. Morphine and on November 6, 2004 at 0548 hours that she

wasted another 3 mg. Morphine.

The MAR record indicates that on November 5, 2004 at 1150 hours, Respondent administered Morphine 4 mg. at time of sheath pull, and on November 5, 2004 at 0100 hours Morphine 1 mg. at time of sheath pull. The MAR also indicates that Respondent gave the patient Tylenol #3, a schedule III Narcotic at time of sheath pull. The MAR further indicates that on November 5, 2004 at 0430 hours, the patient was administered Morphine 4 mg. at time of sheath pull by another nurse. The MAR also indicates that on November 5, 2004, at 0630 hours and at 0700 hours, Respondent administered 2 mg Morphine to this patient. Respondent's records thus indicate that Respondent withdrew Morphine twice on this patient for a sheath pull, yet the patient only had one sheath to pull. Likewise, there was no reason to administer two narcotics (Morphine and Tylenol #3) at the same time, i.e. at the time of the sheath pull. Moreover, Respondent was not the nurse who performed the sheath pull. Furthermore, Respondent was only supposed to administer Morphine to the patient if the pain level of the patient reached the 8-10 level. However, Respondent failed to note or record any patient pain level reading on her nurses notes or elsewhere on the patient's chart.

Patient #130591

b. Physician's orders for this patient on November 4, 2004 indicate Morphine PCA 30 MG IV every four hours. The Omnicell medication station record indicates that on November 6, 2004, at 20:06 hours, and on November 7, 2004 at 0622 hours, Respondent accessed the Morphine PCA syringe drawer but nothing was indicated as being removed and no sign out of the drug was recorded. In fact, Respondent withdrew two Morphine syringes without informing the Omnicell medication station that she withdrew the syringes. The Omnicell medication station record

indicates further that on November 7, 2004 at 1956 hours, Respondent accessed the Morphine PCA syringe drawer and found that there were only two Morphine PCA syringes in the drawer instead of the four syringes would should have been present according to the Omnicell computer. Respondent without removing any of the medication, then input data into the Omnicell computer telling the computer that there is a discrepancy between the computer syringe count and the actual syringe count. Immediately thereafter, on November 7, 2004, at 1956 hours, Respondent again signed into the Morphine PCA syringe drawer and did not return or remove any medication from the drawer.

On November 8, 2004 at 0417 hours, Respondent again accessed the Morphine PCA syringe drawer and again showed no return or removal of medication. The Epidural PCA Flow Sheet for this patient indicates that on November 7, 2004 (charted as November 6, 2004) at 0700 hours Respondent administered 30 mg. Morphine to the patient by inserting a new syringe into the PCA. The Epidural PCA Flow further reveals that on November 7, 2004 at 0800 hours, the patient had infused 4 mg. Morphine within the last four hours and had only 18 mg. Morphine remaining in the PCA. Respondent's charting thus fails to account for 8 mg. of Morphine.

SECOND CAUSE FOR DISCIPLINE

(Possession of Controlled Substances and Dangerous Drugs)

23. Respondent is subject to disciplinary action under section 2761, subdivision (a), as defined in section 2762, subdivision (a), and 4060, on the grounds of unprofessional conduct, in that from on or about December 6, 2003 to on or about January 9, 2004, Respondent obtained and possessed the controlled substances and dangerous drugs, Ativan, Morphine, Demerol and Dilaudid, at will, without physicians' orders when she did not administer or waste the possessed medications as required by

hospital procedures.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

24. Respondent is subject to disciplinary action under section 2761, subdivision (a), on the grounds of unprofessional conduct, in that while employed as a registered nurse, Respondent committed unprofessional acts which directly relate to the qualifications, functions, and duties of a registered nurse, as set forth above in paragraphs 21-22.

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FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence/Incompetence)

25. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1), on the grounds of gross negligence and/or incompetence in carrying out the usual certified or licensed nursing functions in that Respondent obtained and administered controlled substances without a doctor's order or prescription, and made multiple errors and/or falsifications in multiple patient medical records as outlined in paragraphs 21 and 22 above.

FIFTH CAUSE FOR DISCIPLINE

(Dangerous Use of Controlled Substance)

26. Respondent is subject to disciplinary action under Sections 2750 and 2762, subdivision (b), on the grounds of unprofessional conduct, in that Respondent administered to herself a controlled substance without a prescription to an extent or in a manner dangerous or injurious to herself, any other person, or the public or to the extent that such use impairs her ability to conduct with safety to the public the practice authorized by his or her license.

a. The circumstances are as follows: On or about May 20,

2004, Respondent submitted a urine sample to Division of Investigation investigator Dennis Shelley which tested positive for Hydrocodone. Respondent was unable to produce to investigator Shelley a valid prescription for Hydrocodone at the time of the urine sample and had no physician prescription for any opiate from December 26, 2003 until August 9, 2004.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License No.630182, issued to Carrie Sue Armstrong.

2. Ordering Carrie Sue Armstrong to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

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3. Taking such other and further action as deemed necessary and proper.

DATED: 4/25/07

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California

Complainant